DISTRICT OF COLUMBIA
DOH Office of Adjudication and Hearings

DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH Petitioner, v. COMMUNITY MULTI-SERVICES, INC., and CONSTANCE REESE Respondents	Case No.: I-00-40136

FINAL ORDER

I. INTRODUCTION

The Government commenced this action by service of a Notice of Infraction on May 10, 2000. The Notice of Infraction alleged that Respondents Community Multi-Services, Inc. and Constance Resse had violated 22 DCMR 3520.3 by failing to provide preventive and general medical care to a resident of a group home for mentally retarded persons. The Notice of Infraction sought a fine of $500.00.

On May 16, 2000, Respondents filed a timely plea of Deny and requested a hearing on the charge. This administrative court conducted an evidentiary hearing on June 16, 2000. Sharon Mebane, an inspector for the Department of Health, appeared on the Government's

behalf. Respondent Constance Reese appeared on her own behalf and on behalf of Community Multi-Services, Inc.

As discussed in greater detail below, I reopened the record on June 29, 2000 and required the filing of additional documentary evidence. I also gave the parties the opportunity to file any appropriate motions or additional argument in light of that new evidence. Respondents filed the required documentation on July 7, 2000. The parties did not take advantage of the opportunity to file additional papers in light of the new evidence, and the hearing record was closed as of July 17, 2000.

Based upon the testimony at the hearing, the documents admitted into evidence, my assessment of the credibility of the witnesses and the entire record in this case, I now make the following findings of fact and conclusions of law.

II. FINDINGS OF FACT

Respondent Community Multi-Services, Inc. ("CMS") operates a group home for mentally retarded adults located at 3112 13th Street, N.W. Eight mentally retarded adults live there. Respondent Constance Reese is the program director for CMS.

This case concerns the medical care received by one of the residents of the facility, referred to as Client #1. This resident suffers from seizure disorder and has several maladaptive behavior patterns, including head butting and banging, skin picking, and throwing and breaking

items. He has been prescribed various medications, including Tegretol, Depakote and Neurontin to manage his seizures, and Prozac, Trilafon and Mellaril to control his behavior disorders. The facility also has developed a behavior management plan to address incidents of his inappropriate behavior.

The Government relies upon a number of discrete incidents in support of its claim that Respondents failed to provide adequate care to Client #1. Those incidents are discussed separately below.

A. Seizures and Related Symptoms

Client #1 suffered several seizures during March and April 2000. On March 2, 2000, he had a seizure at his day program that lasted about two minutes. CMS did not provide any immediate follow-up care for that seizure, but there is no evidence showing when its staff first knew that the seizure had occurred. Ms. Mebane was the Government's only witness and she based her testimony largely upon her review of the facility's records.[1] She testified that CMS's files contain a memorandum from the day program dated March 2, 2000 describing the seizure, but there is no evidence showing whether CMS received that memorandum before the March 3rd seizure described below. There is also no expert testimony describing what immediate follow-up care, if any, was appropriate after the seizure had passed.

[1] Ms. Mebane prepared a Statement of Deficiencies and Plan of Correction form (a "Deficiency Statement") describing in detail the Government's factual allegations. The Deficiency Statement was sent to Respondents and also was filed with this administrative court. It is part of the record in this matter.

On the morning of March 3, 2000, Client #1 had another seizure. He lay on the floor unresponsive, and would not stand. He was transported to the emergency room, where he was treated and released in the evening. He continued to be weak and unable to walk without assistance for two days after that incident. On March 5th, the facility's nurse recorded Client #1's blood pressure as 156/92 in the morning and 142/86 in the evening. Ms. Mebane expressed the view that recording blood pressure readings in the facility's records was an indication that the nurse believed the readings were unusual. There has been no testimony, however, that any medical intervention was necessary in light of those readings.

On April 2, 2000, Client #1 had another seizure. At 11:30 AM, the morning shift supervisor at the group home reported that he experienced abnormal eye movement and difficulty in standing. He also was unable to eat his lunch. The supervisor took no action other than writing a report on the incident, and leaving it for the evening medication nurse to review. When the nurse arrived that evening, she noted that Client #1 could eat only with assistance (although he usually was able to feed himself) and that his gait was unsteady. She also did not take any action.

Shortly after the medication nurse left the group home, Client #1's condition became worse. The facility's staff then contacted the charge nurse, who was unaware of the previous incidents that day. The charge nurse instructed the staff to monitor his condition and to call her back if he got worse. At 8:15 PM, he was unable to walk and was not responding to painful

stimuli. The staff again contacted the charge nurse, who instructed them to call for an ambulance.

Client #1 then was taken to the emergency room. The emergency room's physician reported that he had suffered a grand mal seizure and was in need of hospitalization. For reasons that are not apparent from the record, the hospital released him at 4:00 AM on April 3rd with instructions that he return to the neurology clinic by 9:00 AM. The facility's staff returned him to the clinic as instructed and he subsequently was transferred to another hospital, which admitted him. That hospital changed one of his anti-seizure medications, substituting Lamitol for Neurontin.

In addition to the seizures described above, the facility's records document two other occasions when Client #1 experienced symptoms that were out of the ordinary, although not described as seizures. On May 26, 1999 the day program staff reported to CMS that he was lethargic and drooling. The facility's primary care physician, Dr. Joseph Nnadike, ordered that he be taken to the emergency room to investigate the possibility that the level of his anti-seizure medications was too high. The hospital reported that the levels were within normal range and did not admit him. CMS and its medical staff did not make any further attempt to determine the cause of those symptoms and, as discussed below, did not arrange for any follow-up.

A similar episode occurred on June 23, 1999. Client #1 was drowsy, unresponsive and incontinent, and was taken to the emergency room. The emergency room staff found no injuries, but recommended follow-up by the primary care physician. Dr. Nnadike found that the

medication levels again were within the normal range. Again there were no additional efforts to discover the cause of his symptoms or to arrange for follow-up evaluations.

B. Follow-up Neurological Evaluations

The facility's records state that Client #1's last visit to the neurologist occurred in February 1999. Dr. Nnadike agreed the neurologist should have seen Client #1 after that time, in light of his medical history as well as the symptoms exhibited in May and June 1999 and the seizures that occurred in March and April 2000. Indeed, he testified that he would be surprised to learn that no such follow-up occurred. Dr. Nnadike was confident that such visits did occur, but I do not credit his testimony on this point. He has no personal knowledge of whether the visits occurred, but only assumes that they did because the nurses never told him otherwise. That is insufficient for me to find that the visits did occur in the face of the contrary indication in the facility's own records. I find, therefore, that Client #1 did not receive the follow-up neurological evaluations that were required in light of the seizures and related symptoms he experienced after February 1999.

C. Medication Levels

The neurologist who had prescribed Depakote and Tegretol for Client #1 also required quarterly monitoring of the level of those medications in Client #1's blood. The neurologist had stated that the level of Depakote in Client #1's blood ordinarily should range between 50 and 100 micrograms per milliliter (µg/ml) and that his Tegretol level should be between 4 and 12 µg/ml.

The facility's records contain both the results of the quarterly monitoring and results from other occasions, such as emergency room visits, when Client #1's blood was checked. As shown below, his medication levels varied, and sometimes were beyond the normal limits prescribed by the neurologist.

	Depakote Level (mg /ml)	**Tegretol Level (mg /ml)**
March 1, 1999	103	9.2
March 22, 1999	88	
May 26, 1999	83.11	10.54
July 1, 1999	98	10.7
October 19, 1999	111	11
October 28, 1999	87	
January 1, 2000	80	10.3
February 3, 2000	100.9	10.1
March 5, 2000	34	0.7
April 1, 2000	130	21

The Depakote levels were outside the recommended range of 50 µg/ml to 100 µg/ml on five of the ten occasions when the Depakote level was checked. The Tegretol levels were outside the recommend range of 4 µg/ml to 12 µg/ml on two of the eight occasions when the Tegretol levels were checked.

Ms. Mebane testified that Client #1's medication levels were a cause for concern, because they exceeded the neurologist's recommended range on several occasions and because the readings varied considerably within the normal range. After reviewing Client #1's records, she consulted the Department of Health's doctor who referred to the levels as "erratic" and expressed the view that the facility should have provided some follow-up care to determine why the levels varied so greatly.

Dr. Nnadike offered contrary testimony. He expressed the opinion that it is difficult to maintain homogenous levels of medications in a patient's blood for many reasons, including food intake and the patient's state of mind, and, therefore, that the variations in the levels of medication within the normal range were not an indication of any problem. Dr. Nnadike also consulted with the neurologist when the Depakote levels exceeded the recommended maximum of 100 µg/ml. The neurologist told him that, while levels between 50 µg/ml and 100 µg/ml were desirable, readings slightly above that level (such as the readings of 100.9 µg/ml, 103 µg/ml and 111 µg/ml) were not a cause for concern. Dr. Nnadike agreed, however, that the reading of 130 µg/ml could be considered dangerous if the patient were exhibiting clinical symptoms associated with seizures. Client #1's Depakote level was 130 µg/ml on April 1, 2000. He was taken to the hospital the next day, and Dr. Nnadike testified that, by doing so, CMS gave him appropriate treatment.

Dr. Nnadike's testimony that it is difficult to maintain homogenous levels of medication in a patient's bloodstream was more convincing than the hearsay statement of the Government's doctor that the levels were a cause for concern because they were "erratic." Accordingly, I do not find that any medical attention was necessary as the result of the variances in the Depakote and Tegretol levels within their respective normal ranges. Similarly, I credit Dr. Nnadike's testimony that no medical attention was necessary for the slight elevations in Depakote levels that occurred on March 1, 1999 (103 µg/ml), October 19, 1999 (111 µg/ml) and February 3, 2000 (100.9 µg/ml). It is undisputed that the neurologist did not believe that those readings

required any medical intervention, and the Government did not present sufficient evidence to the contrary.

I also accept Dr. Nnadike's testimony that CMS acted properly when Client #1's Depakote level reached 130 µg/ml on April 1, 2000. It is undisputed that a Depakote reading at that level, combined with the symptoms experienced by Client #1, indicated that a physician should evaluate Client #1. Client #1, however, *was* evaluated by a physician when he went to the hospital on April 2nd. Although the blood test that showed a Depakote level of 130 µg/ml was taken on April 1st, there is no evidence showing when the laboratory reports showing the results of that test became available. In particular, there is no evidence that CMS was aware of the high Depakote level at any time before Client #1 was taken to the hospital on April 2nd.

Dr. Nnadike's testimony did not address Client #1's high Tegretol level on April 1st (21 µg/ml, compared to a normal range of 4-12 µg/ml). Client #1 received medical attention the next day, however, and there is no basis in the evidence for a finding that CMS should have been aware of the high Tegretol level or that it should have acted sooner than it did.

Both the Depakote (34 µg/ml) and Tegretol (0.7 µg/ml) levels were significantly below the normal range when measured on March 5, 2000, two days after Client #1 was treated at the emergency room for a seizure. The evidence is insufficient to support any finding about the cause of those low levels or the date when Respondents first learned of them. It may be that the low levels of anti-seizure medication predated the seizures of March 2 and 3, and, in fact, were the cause of those seizures. It is also possible that the low readings on March 5th reflected a

separate problem unrelated to the earlier seizures. Dr. Nnadike speculated that the readings might result from a laboratory error but there is no evidentiary support for that speculation. In any event, there is no expert testimony describing any action that Respondents should have taken in light of those readings.

D. Behavior Management Plan

Ms. Mebane visited the group home on April 2, 2000.[2] While she was in the supervisor's office, Client #1 came in and became agitated, apparently because Ms. Mebane was sitting in his favorite chair in the office. He began cursing and banged his head against the wall. A staff member then removed him from the office, took him to the living room, and sat him on a mat there.

The facility's behavior management plan for Client #1 prescribes the appropriate staff response when Client #1 engages in head banging or similar behavior that poses a danger to himself or others:

> "At the first sign of . . . head banging/butting behavior, . . . verbally or physically redirect [Client #1] to a safety zone and instruct him to sit down or lay down. Sit with him and talk quietly to determine the source of his agitation and calm him down. Remain with him singing songs or listening to quiet music for about ten minutes or until the source of agitation can be clarified and/or corrected."

Respondents' Exhibit #1 ("RX-1") at 2.

[2] Client #1's seizure on April 2nd occurred after Ms. Mebane left the facility that day.

The plan describes a safety zone as an area where Client #1 "has no access to the other residents or to property which he can damage and where staff can observe him for possible self-abusive disorders." RX-1 at 1-2. One example of a safety zone is Client #1's favorite couch in the living room. Id. at 1.

From her vantage point in the office, Ms. Mebane was unable to see what happened after Client #1 was taken to the living room. At that time, she was not aware of the behavior management plan. After her review of the facility's records, however, she believed that the staff's actions did not comply with the plan, because the mat in the middle of the living room was not a safety zone and because she did not believe that adequate staff was present to provide the one-to-one supervision required by the plan.

E. Client #1's Individual Habilitation Plan

In response to the order of June 29, 2000, Respondents filed the individual habilitation plan for Client #1 applicable to the period between April 1, 1999 and March 31, 2000.[3] The plan is designated as Court Exhibit #1 and is admitted into evidence. The plan contains specific references to providing medical care for Client #1's seizures. For example, Section VII.B of the plan, entitled "Needs" states: "[Client #1] needs to continue to receive medical support services,

[3] The June 29 Order required submission of "any individual habilitation plan for Client #1 applicable to the period between May 1, 1999 and April 30, 2000." Some of the incidents at issue in this case occurred early in April 2000, and the plan filed by Respondents does not apply to that period. Absent contrary evidence from Respondents, however, I infer that the provisions of the 1999/2000 plan that are discussed in the text do not differ in any material respect from any plan applicable to April 2000 and beyond.

with special attention to nutritional concerns and monitoring of seizures." In addition, the first recommendation of the plan, accepted by the Individual Habilitation Plan team, is for an "[a]nnual physical exam[;] specialty assessments and lab values as indicated." I interpret the requirement for "specialty assessments . . . as needed" to mean that a medical specialist must assess Client #1 whenever his symptoms indicate either that an immediate intervention is needed or that non-immediate evaluation of a chronic condition or a related series of medical problems is indicated. A separate recommendation in the individual habilitation plan requires that Client #1's current behavior management plan be continued.

III. CONCLUSIONS OF LAW

The Notice of Infraction charges a violation of only one regulation -- 22 DCMR 3520.3. That section provides:

> Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident.

As noted in this administrative court's order of June 29, 2000, the regulation describes certain "professional services", but does not establish a standard of conduct for group home operators to follow. The relevant standard of conduct is found in 22 DCMR 3520.1, which requires that every resident of a group home for mentally retarded persons "shall receive the professional services required to meet his or her needs as identified in his or her individual habilitation plan . . . ." In order to establish a violation of that section, therefore, the Government must prove that a group home operator failed to furnish professional services to meet the needs

identified in a resident's individual habilitation plan. Section 3520.3, in turn, identifies specific professional services that a group home operator must furnish to comply with § 3520.1. Thus, the charge that Respondents "violated" § 3520.3 is actually an allegation that they failed to meet their obligations under 3520.1 because they did not provide professional services described in § 3520.3 that are necessary to meet Client #1's needs as identified in his individual habilitation plan.

It follows that the individual habilitation plan is essential in order to decide this case. It is not enough for the Government to show that Client #1 did not receive appropriate medical care. It also must show that he did not receive care that was necessary to meet a need identified in the individual habilitation plan.[4] For that reason, I ordered the filing of a copy of the individual habilitation plan, which is now in evidence as Court Exhibit #1. I will evaluate the Government's various claims in this matter to determine whether it has established that Respondents failed to provide appropriate professional services that meet needs identified in Client #1's individual habilitation plan.

[4] This does not mean that a group home's failure to furnish necessary medical services is punishable only if the services are identified in a resident's individual habilitation plan. Both District of Columbia law and federal law grant group home residents a right to medical care without regard to whether an individual habilitation plan identifies a need for specific medical services. E.g., D.C. Code § 6-1965(g); 42 CFR 483.460 (a)(3). A group home operator's failure to protect that right would violate 22 DCMR 3523.1, subjecting the violator to a civil fine. Alternatively, 22 DCMR 3520.13 may require group home operators to provide professional services not identified in an individual habilitation plan. The Government has not relied upon that regulation in this case.

A. Seizures and Related Symptoms

1. The events of April 2nd and 3rd

As noted above, the individual habilitation plan notes that Client #1 "needs to continue to receive medical support services, with special attention to nutritional concerns and monitoring of seizures." The evidence of the events of April 2nd establishes that he did not receive adequate professional service that met this need. In particular, the evening medication nurse, despite her awareness of the morning shift supervisor's report and her own observations of Client #1, neither took any action nor reported his symptoms to any other members of the medical staff. Consequently, the charge nurse had incomplete information later that night when she received the first report of Client #1's worsening condition. By paying inadequate attention to Client #1's symptoms, the evening medication nurse did not give "special attention to . . . monitoring of seizures" as required by the individual habilitation plan.

The individual habilitation plan also requires that Client #1 receive "specialty assessments . . . as indicated." Respondents did not violate that requirement on April 2nd or April 3rd. Client #1 received a "specialty assessment" when Respondents returned him to the neurology clinic as instructed by the hospital's medical staff.

2. The events of early March

The evidence does not demonstrate any violations of the individual habilitation plan's requirements from March 2nd through March 5th. In view of Respondents' obligation to give

"special attention to . . . monitoring of seizures," it is arguable that they should have been notified immediately of the March 2nd seizure at the day program. The Government failed to prove when the notice was received, however. If notice was received on March 2nd, there was no violation of the "monitoring" requirement of the individual habilitation plan;[5] if, on the other hand, notice was not received until a later date, there was no evidence that Respondents were responsible for any such failure. In either case, therefore, there is insufficient evidence to establish that Respondents violated the requirement of the individual habilitation plan that they pay special attention to the monitoring of seizures. Nor is there evidence of any improper conduct with respect to the March 3rd seizure. The evidence shows that the facility's staff became aware of Client #1's symptoms, reported them appropriately and took him to the hospital promptly. No violation of either the monitoring or the specialty assessment provisions of the individual habilitation plan occurred in connection with that seizure.

The blood pressure reading on March 5th does not establish a violation of any of the provisions of the individual habilitation plan. There is no evidence either that a specialty assessment was indicated as the result of that one reading, or that the reading reflected a failure to give special attention to the monitoring of seizures.

[5] There was no expert testimony that any immediate follow-up was necessary as the result of the March 2nd seizure at the day program. Thus, if the notice was timely, there is no basis to conclude that Respondents acted improperly in the immediate aftermath of that seizure.

B. Follow-up Neurological Evaluation

As discussed above, the evidence shows that Respondents did not violate the "specialty assessment" provision of the individual habilitation plan to the extent that it calls for immediate medical intervention by a specialist. The evidence shows, however, that Respondents did not provide appropriate follow-up by a specialist in light of the symptoms exhibited by Client #1 over the period at issue.

Client #1's last visit to the neurologist occurred in February 1999, even though several significant events occurred after that date, including his emergency room visits of May 26, 1999, June 23, 1999, and March 3, 2000, and his hospitalization on April 3, 2000. Based on Dr. Nnadike's testimony, it is undisputed that follow-up visits to the neurologist should have occurred after February 1999. The facility's failure to arrange for any such visits contravenes the requirement of the individual habilitation plan that Client #1 receive "specialty assessments . . . as indicated." Accordingly, that failure violates the requirement of 22 DCMR 3520.1 and 22 DCMR 3520.3 that Respondents furnish professional services to Client #1 to meet needs identified in his individual habilitation plan.

C. Medication Levels

The evidence of the variations in Client #1's medication levels is insufficient to prove that Respondents failed to provide any of the professional services required by the individual habilitation plan. To the extent that measuring medication levels may be included within

"monitoring of seizures" (an issue I do not decide), the evidence shows that Respondents kept regular records of the levels of Client #1's anti-seizure medications. There is no evidence of any failure to devote "special attention" to those levels.

The evidence relating to the medication levels also does not show a violation of the "specialty assessments . . . as indicated" requirement of the individual habilitation plan. According to the testimony that I have credited, neither the fluctuations of the medication levels within the normal range nor the slight elevations in Client #1's Depakote levels on three occasions required any medical intervention. On the one occasion that both the Depakote and Tegretol levels were significantly higher than the normal range, CMS arranged for prompt medical attention from the hospital, including a "specialty assessment . . . as indicated" by the hospital. Finally, because the Government did not introduce any expert testimony, the evidence does not show what "specialty assessment" or other medical attention was indicated for the low medication levels in March. Thus, the evidence concerning the variations in the levels of medication in Client #1's blood does not prove that Respondents failed to provide any of the professional services necessary to meet the needs identified in his individual habilitation plan.

D. Behavior Management Plan

The parties disagree over whether the actions taken by the direct care staff in response to Client #1's temper tantrum on April 2nd complied with his behavior management plan. The major areas of disagreement are whether the staff took him to an appropriate safety zone and whether sufficient staff members were present to afford him one-to-one supervision. I will not

resolve those disagreements, however. The only violation alleged in this case is a failure to provide the professional services required by 22 DCMR 3520.1 and 3520.3. As discussed below, direct care staff's non-compliance with a behavior management plan does not violate those sections.

Section 3520 of 22 DCMR deals exclusively with professional services. The regulations make it clear that the implementation of a behavior management plan by a group home's direct care staff is not included within the professional services governed by that section. According to 22 DCMR 3520.2, the professional services required by § 3520 "may include, but not be limited to," services provided by practitioners in fields such as medicine, dentistry, education, nutrition, nursing, occupational therapy, physical therapy, psychology, speech and language therapy, social work and recreation. Although the use of the term "may include" indicates that § 3520.2's list of professions is not exhaustive, the principle of *ejusdem generis* suggests that the services required by the regulation are all similar to those listed.[6] The occupations listed in § 3520.2 all require specialized formal education (at least a bachelor's degree). Moreover, practitioners of those professions offer services to members of the public other than mentally retarded persons.[7]

[6] The doctrine of *ejusdem generis* provides that when a statute or regulation uses a general term along with an enumeration of specific terms, the general term is limited to things that are similar to those that have been enumerated. 2A NORMAN J. SINGER, SUTHERLAND ON STATUTORY CONSTRUCTION § 47.17 (6th ed. 2000). The District of Columbia Court of Appeals regularly employs the doctrine as an aid in construing statutes and regulations. *See, e.g., Markowitz v. United States*, 598 A.2d 398, 408 (D.C. 1991), *cert. denied* 506 U.S. 1035 (1992); *Edwards v. United States*, 583 A.2d 661, 664 (D.C. 1990); *Vann v. District of Columbia Bd. of Funeral Directors & Embalmers*, 480 A.2d 688, 695 (D.C. 1984); *Keefe Company v. District of Columbia Bd. of Zoning Adjustment*, 409 A.2d 624, 626 (D.C. 1979); *United States v. Brown*, 309 A.2d 256, 258 (D.C. 1973).

[7] In *Keefe Company v. District of Columbia Bd. of Zoning Adjustment*, 409 A.2d 624 (D.C. 1979), the court affirmed an agency's use of *ejusdem generis* to limit the phrase "similar

Unlike members of the professions enumerated in § 3520.2, direct care staff are not required to achieve any specified level of formal education. See 22 DCMR 3509.1(b) ("Direct care staff shall be eighteen (18) years of age and be capable of carrying out responsibilities as outlined in the job description.") Moreover, unlike doctors, nurses and the other professionals listed in § 3520.2, direct care staff members are not members of a profession that offers services to the general public; instead their role is limited to providing services to group home residents. See 22 DCMR 3599.1 (defining "direct care staff" as "individuals employed to work in the GHMRP who render the day-to-day personal assistance residents require in order to meet the goals of their individual habilitation plans"). The services furnished by direct care workers, therefore, are not included within the professional services regulated by 22 DCMR 3520.

Because direct care workers do not provide "professional services" within the meaning of § 3520, any failure by them to comply with a behavior management plan is not a violation of § 3520.1's requirement that a facility provide professional services. This does not mean that direct care staff can ignore a behavior management plan with impunity. To the extent that a behavior management plan is incorporated into an individual habilitation plan, failure to comply with the behavior management plan would violate 22 DCMR 3521.3, which requires group home operators to "provide habilitation, training and assistance to residents in accordance with the

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professional person" in a zoning regulation to include only persons with: "(1) professional education; (2) a code of ethics and some principles of practice through a professional organization; and (3) professional licensing . . . ." *Id.* at 626. Because the zoning regulation at issue in *Keefe* served a different purpose than the professional services requirements at issue in this case, and because the list of enumerated professions in the zoning regulation was different (and narrower) than the list in 22 DCMR 3520.2, the term "professional" should not necessarily have the identical meaning in both regulations. Consequently, my interpretation of "professional services" in § 3520.2 is somewhat broader than the Board of Zoning Adjustment's interpretation of "similar professional person" in *Keefe*.

resident's Individual Habilitation Plan." Because no violation of that section was charged in this case, I do not decide whether Respondents failed to comply with the behavior management plan.

E. Fine

As discussed above, I have concluded that the evidence establishes two instances in which Respondents did not furnish professional services required to meet Client #1's needs as identified in his individual habilitation plan. CMS did not pay special attention to the monitoring of his seizure on April 2, 2000, and it did not provide the follow-up specialty assessments that were indicated as the result of his seizures and related symptoms between May 1999 and April 2000. That evidence could support a conclusion that Respondents are liable for two separate violations of 22 DCMR 3520.3 and that two separate fines should be imposed. The Notice of Infraction, however, alleges only a single violation and seeks a single fine of $500.00. Section 3239.2(e) of 16 DCMR authorizes a fine in that amount for a single violation of any of the provisions of 22 DCMR 3520, and I will impose it.

IV. FINAL ORDER

Based on the foregoing findings of fact and conclusions of law, it is, this _____ day of _____, 2000:

ORDERED, that Respondents shall cause to be remitted a single payment totaling **FIVE HUNDRED DOLLARS ($500.00)** in accordance with the attached instructions within twenty (20) calendar days of the date of mailing of this Order (fifteen (15) calendar days plus five (5) days for service by mail pursuant to D.C. Code § 6-2715). A failure to comply with the attached payment instructions and to remit a payment within the time specified will authorize the imposition of additional sanctions, including the suspension of Respondents' license or permit pursuant to D.C. Code § 6-2713(f).

FILED 08/30/00

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John P. Dean
Administrative Judge